Michigan Department of Community Health
Children's Special Health Care Services

CLIENT TRANSPORTATION AUTHORIZATION AND INVOICE

Transaction Type
☐ REIMBURSEMENT ☐ RECONCILIATION
Mode of Transportation

SECTION 1 – Authorization Information *(To be completed by Local Health Department or CSHCS Staff)*

Client Name (Last, First, Middle Initial)	Client Birth Date	Type of Travel
		☐ In-State *(Box A)* ☐ Borderland *(Box A)* ☐ Out-of-State *(Box B)*
County of Residence	Client ID Number (or Social Security Number)	

DESTINATION (facility, city, state)	Authorized Travel Date(s) From	To
1)		
2)		
3)		
4)		

Describe/explain reason for requesting an exception to policy

A	LHD Representative Name *(Printed)*	Office Phone Number	**B**	Has Out-of-State medical care and treatment been authorized? ☐ YES ☐ NO

In-State Authorization–LHD Authorized Signature	Date Signed	Out-of-State Authorization–CSHCS Authorized Signature	Date Signed

SECTION 2 – Invoice and Verification *(To be completed by the transporting person **or** person being reimbursed)*

Name of Transporting Person (Last, First, Middle Initial)	Social Security Number - -

Street Address (number & street, including apt., lot number, etc.)	City	State	Zip Code

	Departure City	Destination City	Date of Departure	Date of Return	Round Trip Miles	Total Number of Days
1)						
2)						
3)						
4)						

A)	Total Number of Nights of Lodging **(receipts required)**	
B)	Total Number of Days for Meals (Client/Outpatient ONLY) - **Out-of-State ONLY**	
C)	Total Number of Days for Meals (Adult/Parent ONLY) - **Out-of-State ONLY**	
D)	Total Number of Miles	
E)	Total All Other Expenses - **receipts required** *(Tolls, fares, cab, ferry, bus, train, etc.)*	

F) Lodging Reimbursement:	G) Meal Reimbursement:
☐ To Transporting Person ☐ To Facility/Will be direct billed	☐ To Transporting Person ☐ To Facility/Will be direct billed

- I verify that the appointment(s) was kept for the client on the date(s) shown above.
- The expenses incurred are true, complete, and accurate.
- If the actual expense is less than any advance I may have received, I will reimburse the difference to the State of Michigan.

Transporting Person's Signature	Phone Number	Date Signed

Michigan Department of Community Health
Children's Special Health Care Services

CLIENT TRANSPORTATION AUTHORIZATION AND INVOICE

Instructions for Completion (MSA-0636)

GENERAL INSTRUCTIONS:

- CSHCS does not reimburse transportation expenses unless they have been pre-authorized.
- Answer all questions. Reimbursement will be delayed if the form is not completed accurately.
- Fill in information pertaining to your reimbursement only (e.g., do not include meals or lodging if facility has given you meal tickets [vouchers] and is direct billing MDCH).
- If you need assistance, contact your Local Health Department or the Family Phone Line at 1-800-359-3722.
- Payment is based on set fee screens.
- Type or print firmly and legibly.
- Authorization is only for one month per form.
- If information exceeds the available number of lines, complete and attach additional sheets as needed.
- All original receipts must be attached. Receipts are not needed for meals or gas.
- Reimbursement cannot be made if this invoice form is received more than 90 days from the date of service.
- Transaction Type must be indicated with an "X." *(Upper right corner)*
- Indicate Mode of Transportation (e.g., car, taxi, bus, plane, ferry, train, other/explain)

SECTION 1: To be completed by the Local Health Department or the CSHCS Division.

- Enter all of the client's identification information.
- Indicate type of travel.
- Enter name of facility/provider, city, and state.
- Enter dates of authorization. Do not put "until discharge." If uncertain of discharge date, approve for a specific amount of time not to exceed one month.
- Explain any exceptions to the current reimbursement policy. All exceptions to current policies require CSHCS Division approval.
- For In-State travel, the LHD staff must authorize and sign in Box A (if approved). Borderland is treated as In-State. (Consult Michigan Medicaid Provider Manual for guidelines on Borderland). LHD is not to sign if Out-of-State.
- For Out-of-State travel, the CSHCS Division determines authorization and signs (if approved) in Box B. Form will be mailed to the client (family).

SECTION 2: To be completed by the transporting person (the person being reimbursed).

- Enter all of the transporting person's identification information, including the social security number. The transporting person is the person being reimbursed.
- Departure City: Enter the name of the city where the trip began.
- Destination City: Enter the name of the city where the client was taken.
- Date of Departure: Enter the date(s) the trip(s) actually began.
- Date of Return: Enter the date(s) the trip(s) actually ended.
- Round trip miles: Record total miles pertaining to medical service for each trip.
- Total number of days: Record the total number of days of each trip.
- Enter total number of nights of lodging if the facility is not billing MDCH. **Receipts are required.**
- **Out-of-State only.** Enter total number of days for outpatient client's meals. (Meals are not reimbursable for in-state travel.)
- **Out-of-State only.** Enter total number of days for meals for one parent (adult) if the facility is not submitting the bill. (Meals are not reimbursable for in-state travel.)
- Enter total number of miles.
- Enter the total dollar amount of all other expenses (i.e., toll charges, parking, cab, bus, or train fares). **Receipts are required.**
- Indicate in F and G whether reimbursement goes to transporting person or to the facility (direct bill).
- Read the verification statement carefully.
- Sign and date this form after the trip or at the end of the month if more than one trip was taken during the same approved month, but within 90 days. Supplying a phone number is optional, but may expedite claims if Payment Area has questions.

MAILING INSTRUCTIONS:

The **PINK** copy, and **copies** of **all receipts** are to be retained by the family. Mail the **WHITE** copy of this form, along with required receipts, to:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CSHCS - TRANSPORTATION
PO BOX 30720
LANSING, MI 48909

Completion: Is Voluntary, but is required if reimbursement from CSHCS Program is desired
Authority: Title V of the Social Security Act

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.